WORK OF A CHILD GUIDANCE CLINIC*

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The child guidance clinic is an essay in the field of mental hygiene, and its aim is to deal with the "difficult" or "problem" child. This term covers a range of cases whose essential feature is a disorder in the sphere of behaviour and, while it does not of course correspond to any precise clinical entity, it denotes a fairly well marked group of patients which will be familiar to every practitioner. We may roughly define the difficult child as one who, as a result of the operation of either endogenous or exogenous causes, is maladjusted to the environment in which it has to live and manifests this maladjustment in disturbances in behaviour.

The variety of conditions covered by this definition will be apparent from the following list of disorders accepted for treatment at the New York Institute for Child Guidance.

1. Children who present problems because of their socially unacceptable behaviour (whether legally delinquent or not), such as: temper tantrums, fighting, teasing, bullying, disobedience, "show off" behaviour, truancy, lying, stealing, rebellion against authority, cruelty, sex difficulties, etc., shown at home, school, or elsewhere.

2. Children who present problems manifested chiefly in personality reactions, such as: seclusiveness, timidity, sensitiveness, fears, cowardliness, excessive imagination and fanciful lying, "nervousness," excessive unhappiness and crying, stubbornness, selfishness, restlessness and overactivity, unpopularity with other children, and the like.

3. Children who present problems in habit-formation, such as: sleeping and eating difficulties, speech disturbances (such as stammering, thumb-sucking, nail-biting, masturbation, prolonged bed-wetting, etc.

All these disturbances have long been familiar to the physician, but their effective treatment has been beset by serious difficulties. In former days the difficulties arose because the nature of the disturbances was very inadequately understood, and their causation was explained by concepts which were narrow and inaccurate. On the one hand, a number of the phenomena were not recognized as belonging to the sphere of disorder, but were thought to be manifestations of "naughtiness" and original sin. On the other hand, a too exclusive emphasis was laid upon physical factors, and the causes of the evil were sought only in disease or disordered functioning of one or other organic system. So long as conceptions of this kind held the field therapeutic effort was necessarily limited to the remedying of whatever organic factors could be found, and the use of reprimand and discipline.

The results achieved by this method of approach were disappointing, and the advance of knowledge gradually brought about a radical change of orientation with regard to the whole problem. The change which has occurred may be said to have involved a progression from an ethical to a physical conception, and thence to one predominantly psychological and biological. It began to be appreciated that the causation was by no means so simple as had been supposed, and that in most cases a multiplicity of converging causal threads had to be disentangled before the mechanism of production could be understood. These threads led in various directions, to the parents, the home conditions, the school, as well as to the patient's constitutional make-up, and the habits of functioning of his body and mind. Only when all such factors had been investigated and appraised, both in themselves and in their interrelationships, could the nature of the child's condition be grasped, and appropriate therapeutic measures instituted.

With the increasing recognition of the complexity of factors involved, the task confronting the physician became correspondingly more formidable. The nature of this task will be apparent if we consider rather more in detail the character of the problem. The child is manifesting its disordered behaviour because of a failure of adaptation to its environment, due either to endogenous or exogenous factors and to their interaction. These factors may be of either a physical or mental order, and we must begin with the conception of the child as a psycho-physical organism reacting to an environment composed of material, mental, and social constituents, and disturbed in its reactions by faults involving an uncertain number of these various components. Hence the investigation which must precede treatment will require to ascertain something about all these things, and perhaps a great deal about some of them. We must know the child's physical and mental make-up, and appreciate the possible bearing which factors of either of these two groups may have upon the problem at issue. In particular we must be able to appraise the child's intellectual capacity, and temperament peculiarities, so as to understand the machinery with which he has to make his adaptation to life and environment. We must know the circumstances of his home and school life, and something of the sort of people with whom he comes in contact in both these environments. Finally, if our investigation is to lead to adequate treatment, we must have some machinery available whereby a modification of environmental factors, either in the home or in the school, can be attempted.

If we inquire why the treatment of the difficult child necessitates so elaborate an attack and one directed along so wide a front, the answer is that in behaviour problems we are concerned, not with disease of some particular organ or system, but with the reactions of a patient as a whole individual. With whole individual reactions all kinds of intrinsic and extrinsic factors and relations may have to be taken into account.

If the problem facing the physician who deals with the difficult child is so complex and accompanied by so many ramifications, it obviously cannot be easily solved by his individual efforts. Apart from the time involved, adequate investigation of the child's intellectual and other capacities cannot be made without special training and constant experience, and a satisfactory estimation of the home, school, and other environmental factors can only be carried out by a doctor who is able personally to visit these environments, and who has the necessary leisure to explore them. These requirements can obviously not be met under the conditions usually holding in a hospital out-patient department, and, if the problem is to be successfully attacked, some kind of team work must be organized.

CHILD GUIDANCE MOVEMENT IN AMERICA

It was the recognition of these essential facts which led to the foundation of the child guidance movement in America. This movement may be said to have commenced with the pioneer work of Dr. William Healy in the sphere of juvenile delinquency, and it has rapidly developed during the past ten years. The development has been largely dependent upon the generous assistance provided by the Commonwealth Fund, which has not only established demonstration clinics in various cities in the United States, but has in New York founded and maintained an Institute for Child Guidance in which there is

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every possible facility for the development and extension of child mental hygiene. The Commonwealth Fund has further extended its assistance to this country, and has completely financed for a limited period a child guidance clinic in London, which was opened in 1930. This is now in full activity, and it is hoped that, when the aid of the Commonwealth Fund is no longer available it will have so proved its value that other means of support and maintenance will be found for it. In addition to this clinic others have been established both in London and the provinces, whose methods and general aims are closely similar, and it may be said that the child guidance clinic now promises to become an integral part of our medical armoury.

CONSTITUTION OF THE CLINIC

The essential feature of a child guidance clinic consists in the employment of a team of three persons, a psychiatrist, a psychologist, and a social worker. These three persons investigate the patient and his environment from their respective standpoints, discuss and collate their results at a joint conference, and decide upon an appropriate line of treatment in the light of the causal factors which have been elicited. During the progress of the treatment special work may be assigned to each of the three persons constituting the team, according to the particular directions in which action is indicated, and further conferences are held to guide and co-ordinate the treatment required.

The psychiatrist is the head of the organization, and is ultimately responsible for the entire direction of the case. In addition to his function as a general supervisor and director he has to undertake those aspects of the case which fall within his special province. These include not only the investigation of the child's mental state, but also a physical examination in which all possible factors capable of producing an effect upon behaviour and adaptation have to be given their due weight. These latter factors are often of fundamental importance, particularly the metabolic disturbances so frequent in difficult children, and unless appropriate measures are instituted to deal with them the problem cannot be adequately solved. The psychiatrist must therefore be something more than a psychiatrist. He must combine in himself the functions of a medical psychologist and of a paediatrician, and although it may perhaps be maintained that in the sphere of behaviour problems the medical psychologist must play the dominant part, there must be no possible risk of the purely paediatric aspects failing to receive their proper consideration. In some clinics a paediatrician is added to the team and relieves the psychiatrist of his responsibilities on the physical side, but considerations of expense generally make this scheme impracticable. It is clearly desirable, however, that a paediatrician should be available in a consultative capacity, to whom exceptional cases could be submitted for an opinion.

The most important duty of the psychologist is to estimate the child's intellectual equipment, so as to determine the capacities of the weapon whereby adaptation has largely to be achieved. This estimate is made by the employment of the various standardized tests which now enable us to measure in a fairly satisfactory manner the intelligence and educational acquirements of the patient. The intellectual capacity thus determined is expressed as a proportion of that to be expected in an average child of the same age, the so-called "intelligence quotient" or I.Q. It is extremely important that those tests should not be carried out in a mechanical manner, and they are indeed likely to produce absolutely fallacious and misleading results except in the hands of a trained and experienced investigator. In addition to this task the psychologist may be able to throw most helpful light on the case by observation of the child's attitude and behaviour during the testing, and may be able to assist materially in the subsequent treatment by steering the patient through difficulties of various kinds which may exist in educational activities, for example a specialized inability to learn some one subject.

The function of the social worker is to obtain full information with regard to the environmental conditions and past history of the child, and to take whatever action is decided upon in the way of attempting to modify environmental factors. It will be necessary for her to visit the home, to get into touch with teachers at the school, and to act as a liaison officer between the clinic and the various social and charitable agencies whose aid may be required in carrying out plans for the child's welfare. To fulfil such multifarious and responsible duties as these the social worker must not only possess exceptional ability and tact, but must have undergone a thorough and specialized training.

CRITICISMS

I have made no attempt to do more than to set out in general terms the principles upon which the methods of the child guidance clinic are based. The details of the work carried out and the description of illustrative cases I am leaving to Dr. William Moodie, who follows me in this discussion, and who, as the director of the London Child Guidance Clinic, has a far more intimate practical acquaintance with the actual work than has fallen to my lot. I shall try to evaluate, however, the contribution to practical medicine which the child guidance clinic is able to make, and particularly to enumerate the criticisms which may be levelled against it, in the hope that they will be dealt with in the ensuing discussion.

It is beyond question that the clinic is an efficient weapon for dealing with the difficult child, and a better weapon than any hitherto devised. A doctor with a liking for this sort of case, a great deal of special experience, and ample time, may obtain excellent results by his individual effort, and may gain more by having all the threads in his own hand than he loses by not having at his disposal the organized team of the clinic. But these requirements are rarely fulfilled, and in general the assistance of the clinic will be invaluable to the harassed practitioner, who has neither the time nor the opportunity to deal adequately with a class of case which, though apparently so trifling, involves nevertheless a great expenditure of effort.

It may be pointed out that, in spite of the fact that these troubles often appear to possess only minor importance, they may be fraught with most serious consequences if they are left uninvestigated and untreated, and that therefore the clinic, in addition to the services it is able to offer to the individual patient, has a considerable value to the community because of what it is able to effect in the sphere of prophylaxis. It will be remembered that the child guidance movement had its roots in the study of juvenile delinquency and the endeavour to modify those factors upon which it was believed that the development of delinquency depended. Further investigation has certainly tended to confirm the view that asocial conduct can in many cases be traced back to the operation of various endogenous and environmental causes, which are capable of being elicited and removed by the machinery of a child guidance clinic. The work of the clinic can therefore claim to be of considerable assistance in the prevention of delinquency, and a close association between clinic and children's court has produced practical results of very great value.

A further prophylactic function of the clinic concerns the psychoneuroses, the conditions formerly known as "functional nervous disorders." In the investigation of developed adult cases of these disorders it is customary

to find a web of remote causes extending back into the childhood of the patient, and it is reasonable to suppose that, if these causes had been disentangled and remedied during the actual period of childhood, the later psychoneurosis could not have subsequently developed. The great importance of the early years of childhood as the phase in which the ultimate fortunes of the individual are rigidly determined has been emphasized by many otherwise completely divergent schools of thought. The Fathers of Port Royal are reported to have said that if they had a child for the first six years of its life they did not care who taught him later. The psycho-analytical school believe that the essential structure of the mind is fashioned in the first few years of life, and that later psychoneuroses can only grow in soil which has been specially prepared in that early period. The behaviourists, again, with their view of the infantile mind as something like a *tabula rasa* except for a limited number of reflexes capable of endless variations by the "conditioning" which occurs in early life, must necessarily attach fundamental importance to the management of childhood. It would appear, therefore, that the child guidance clinic can play a great part in remedying minor disturbances in childhood which may, if left untreated, pave the way for all kinds of more serious conditions in later years, and particularly for the whole range of the psychoneuroses.

We do not know how far a similar prophylactic function may apply to the later development of actual psychoses. Even here, however, there are indications of a possible line of attack. Considerable evidence has accumulated in recent years for the view that certain psychoses, manic-depresssive and schizophrenic, are only likely to develop in certain types of individual, and that the recognition of the type in the normal person will enable us to predict the variety of psychosis which is liable to develop, though this development is of course by no means inevitable. If this relationship can be established there would appear to be ground for hoping that careful and adapted management of a child in whom the characters of a particular type were prominent might lessen the chance of the corresponding psychosis developing in later life. For example, the boy of marked "introvert" type—seclusive, tending to live in himself, and unable to adapt easily to social relationships—might be trained to modify these reactions in some measure, and hence to avert the risk of a later schizophrenic development.

So much for the services which the child guidance clinic may perform, some of them solid and of unquestionable value, others much more hypothetical and only to be regarded as hopeful avenues for exploration. Let us now consider the criticisms which may be levelled against the clinic as a part of our practical medical armoury. The first obvious objection is that the employment of a team of workers, each investigating the patient from a particular angle, involves the loss of that close clinical and personal touch which characterizes the work of every good physician. It is true that the method of holding frequent conferences between the members of the team goes some way to obviate this criticism, but it is nevertheless valid enough, and the physician with time and opportunity will probably prefer to dispense with a social worker, if not with a psychologist, and to do their share of the work himself. This is indeed likely to be necessary when dealing with patients of certain classes, because the employment of a social worker would be impracticable except in very limited ways. For great numbers of patients, however, and particularly for those whose only alternative centre of treatment would be a hospital out-patient department, the objection is irrelevant, because no other adequate scheme is possible. Whether or not the individual is better than the team method is not of great moment when only an absolutely ineffective individual attack is feasible. We may admit the disadvantages of the team approach, but clearly these are outweighed by the advantages.

The second and most formidable criticism concerns the costliness of the child guidance clinic. In view of the amount of time and labour involved in each case the cost per patient is undoubtedly very high, and unless the expenses can be cut down it is difficult to see how a wide extension of child guidance work will be possible. By skilful organization, however, particularly the classification of cases by the psychiatrist, so that the whole machinery of the clinic is only brought into play where it is needed, considerable economies in time and effort can be effected, and hence the total cost of working greatly reduced. At the best, however, the method will remain an expensive one, and there are some who believe that the chief value of the clinic will ultimately be, not the services it renders to the individual child, but the training of workers and investigators who will carry a trained understanding to schools, courts, and other places where it will prove capable of fertile employment.

Other criticisms are levelled at the method of treatment in itself, mainly on the ground that it does not conform to the method which the objector believes to be the only valid approach. Criticisms of this kind may come from several quarters, and are clearly mutually destructive. The principle firmly maintained by most of the child guidance clinics in America and in this country, and which I believe to be fundamentally sound, is that in this work a catholic point of view, with the avoidance of a narrow adherence to the doctrine of any particular school, is absolutely necessary. We must be prepared to view each case from the widest possible angle, to consider that all kinds of factors may be playing a part, and to do our best to modify those factors which seem to be contributing to the undesirable situation by any and every means which presents itself to our hand. This is the attitude of the child guidance clinic, and it would appear to offer a line of attack which cannot fail to be fruitful.

THE DIABETIC ACUTE ABDOMEN

A TYPICAL CASE

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It is well recognized that severe ketosis and acidosis in the diabetic may be associated with digestive disturbances, such as nausea, vomiting, constipation, and colic; but little attention, if any, has been drawn in this country to the violent and puzzling abdominal pains that may occur, although a few cases have been recorded in America[1 2 3]. In such a case the signs and symptoms in the abdomen may simulate so closely those of an acute abdominal catastrophe that surgical intervention has been needlessly undertaken. The differential diagnosis was especially difficult in the case we are recording, in which a high polymorphonuclear leucocytosis was present.

HISTORY OF THE CASE

The patient, a robust man of 31, was known to have had fairly severe diabetes since 1924. He was investigated in this hospital in 1928, and went home taking 40 units of insulin twice a day and a liberal qualitative diet. He kept